



**April 2007**

*Mission: to transform the health care system through information and technology to improve patient safety and health care quality, lower costs, and coordinate care.*

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**House Passes Genetic Non-discrimination Bill**

After years of inaction, the House of Representatives finally [passed the Genetic Information Nondiscrimination Act](#) (H.R. 493) on April 25. The legislation is considered crucial to advancing genomic medicine, which offers hopes of breakthrough cures and new prevention opportunities by tailoring medicine to an individual's specific genetic makeup. Concern was expressed during markup in the Energy and Commerce Health Subcommittee that segregating genetic information from personal and electronic medical records could diminish gains health information technology allows in productivity or quality. The final bill passed 420-3, with Dr. Francis Collins, Director of the National

Human Genome Research Institute and who has worked for the bill's passage for fourteen years, in attendance in the House Gallery. Similar legislation has passed the Senate unanimously in the past and has passed committee this year, however floor consideration is being blocked by Sen. Tom Coburn (R-OK).

### **CMS Releases Physician Performance Measures**

CMS has unveiled the [performance measures it will use to assess physician quality](#) in its new pay-for-performance program slated to begin this July. Under the new Physician Quality Reporting Initiative, authorized by Congress in year-end tax and health care legislation last year, doctors who report on the 74 measures identified by CMS can receive payment bonuses up to 1.5%. The measures look at physician adherence to best practices for the treatment of diseases such as diabetes, depression, heart diseases, stroke, osteoporosis, and a number of other common conditions. The program mirrors a hospital pay-for-performance program that has been in place for several years. According to Herb Kuhn from CMS, the agency is already planning to add measures looking at such things as use of electronic health records and e-prescribing for 2008, though the initiative is only authorized for the second half of 2007 at present.

### **Dr. Rob Kolodner named Second Permanent National Coordinator for Health I.T.**

HHS Secretary Mike Leavitt [announced the appointment of Robert M. Kolodner, M.D.](#), to head the Office of the National Coordinator for Health Information Technology (ONC) at HHS. Dr. Kolodner has been serving as the Interim National Coordinator for Health IT since September 20, 2006. Dr. Kolodner joined HHS from the Department of Veterans Affairs' (VA) Veterans Health Administration (VHA), where he was Chief Health Informatics Officer. In that role, he was chief advisor to the VA's Under Secretary for Health on information technology issues and oversaw the development of the VA's renowned electronic health record, VistA.

As National Coordinator for Health IT at HHS, Dr. Kolodner will serve as principal advisor to Secretary Leavitt on all health IT initiatives. He will also continue to develop, maintain, and direct the implementation of the strategic plan to guide nationwide adoption of interoperable health IT to reduce medical errors, improve quality, and produce greater value in health care, as well as coordinate federal agencies' health I.T. activities.

### **Groups Plan "National Health I.T. Week" for May**

Over 60 separate organizations with diverse perspectives on health care will be gathering in Washington, D.C. during the week of May 14-18 to work together under one banner with the goal of improving health care efficiency, quality, cost-effectiveness and patient safety through health IT. This ["National Health IT Week 2007"](#) will coincide with several partner events, including [HIMSS Advocacy Day '07](#), which promises to exceed 2006 attendance levels of 250 high-level federal, state, provider, vendor, pharma and payer leaders from 48 states and 25 associations who assembled to bring the health IT

message to Capitol Hill. The Senate Quality Improvement and Healthcare IT Caucus will be hosting a Solutions Showcase which is open to all on Wednesday, May 16, from 3:00 - 5:00 p.m. in Room G-50, Dirksen Senate Office Building.

### **Gonzalez, Gingrey Introduce Health I.T. Bill for Small Physicians Practices**

Caucus member Rep. Charles Gonzalez (D-TX) and Rep. Phil Gingrey (R-GA) introduced the [National Health Information Incentive Act](#) (H.R. 1952), bipartisan legislation that creates incentives for small physician practices to adopt health information technology. Gonzalez, chairman of the Small Business Committee's Subcommittee on Regulation, Healthcare, and Trade, and Gingrey each introduced separate bills in the 109<sup>th</sup> Congress targeting the small physician practices that have represented one of the most vexing challenges to health I.T. adoption. The new bill combines tax breaks favored by Gingrey with authorization of new grants, loans, and Medicare bonuses. Neither the Energy and Commerce Committee nor the Ways and Means Committee, which have jurisdiction over the legislation, have given any indication if or when it might be considered.

### **Federal Legislation Introduced to Establish Rural Health Quality Advisory Commission**

Representatives Stephanie Herseth (D-SD), Greg Walden (R-OR), and Earl Pomeroy (D-ND) have introduced H.R. 1651, the [Rural Health Quality Advisory Commission Act of 2007](#). The Commission would develop, coordinate, and facilitate implementation of a national plan for rural health quality improvement. The national plan would identify objectives for rural health quality improvement; identify strategies to eliminate known gaps in rural health system capacity and improve rural health quality; and provide for Federal programs to identify opportunities for strengthening and aligning policies and programs to improve rural health quality.

### **CMS Clarifies Guidelines for National Provider Identifier (NPI) Deadline Implementation**

CMS has announced that it is implementing a contingency plan for covered entities (other than small health plans) who will not meet the May 23, 2007, deadline for compliance with the [National Provider Identifier \(NPI\) regulations](#) under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. With the May deadline just ahead, HHS received a number of inquiries expressing concern over the health care industry's state of readiness. While CMS is encouraging covered entities to make every effort to ensure that they and their associates are ready for the deadline, covered entities that incorporate contingency plans into their processes have up to May 23, 2008 to ensure compliance. If a complaint is filed against a covered entity, CMS will evaluate the entity's "good faith efforts" to comply with the standards and would not impose penalties on covered entities that have deployed contingency plans to ensure that the smooth flow of payment continues. CMS will end the "good faith efforts" review in May 2008.

## **National Quality Forum Releases Updated Patient Safety Reports and Newly Endorsed Quality Measures**

In March 2007, the National Quality Forum (NQF) released updated and newly endorsed consensus standards and preferred practices to promote quality improvement and patient safety, including:

- An updated [Safe Practices for Better Healthcare](#), a compilation of 30 practices that should be universally followed in applicable healthcare settings to reduce the risk of harm resulting from processes, systems, or environments of care.
- An updated [Serious Reportable Events in Healthcare](#), a compilation of 28 serious, avoidable adverse events that, if monitored and publicly reported, would lead to substantial improvements in patient safety. As of November 2006, 25 states required licensed healthcare facilities to report at least some form of adverse events related to healthcare, including California, Connecticut, Illinois, Indiana, Minnesota, New Jersey, Oregon, Washington and Wyoming; many other states are actively considering reporting programs based on the NQF list. The new publication updates the original 2002 report, adding one new event (artificial insemination with the wrong donor sperm or egg) and providing updated evidence and implementation guidance on the 27 events identified in the original report.
- Newly endorsed consensus standards for diagnosis and treatment of [breast and colorectal cancer](#) and [pneumonia mortality in acute care settings](#).

## **Over 50 Percent of State Medicaid Programs Offer P4P; More Planning Initiatives**

A [Commonwealth Fund report](#) on a survey of state Medicaid programs found that more than 50 percent of programs have pay-for-performance (P4P) initiatives currently and nearly 85 percent of states will have such initiatives within five years. The report describes the P4P programs and provides information on measures and incentives included and evaluation and reporting methods used. Survey results indicated that the primary objective of P4P efforts is to improve quality rather than reduce costs and that most Medicaid directors and staff members believe the efforts are improving care.

## **Physicians Express Cautious Support for Pay-for-Performance**

A recent [national survey published in Health Affairs](#) finds that internists are supportive of financial incentives for quality, but are concerned about possible unintended consequences. Of the more than 550 general internists from across the United States who responded to the survey, nearly 75 percent felt that physicians should receive financial incentives for providing quality care if quality can be accurately measured; however,

only 30 percent agreed that current quality measures are accurate enough. Most physicians were concerned that current measures are not adequately adjusted for patients' medical conditions (88 percent) or socioeconomic status (85 percent); that measuring quality may lead physicians to avoid high-risk patients (82 percent); and that measuring quality will divert physicians' attention from important but unmeasured areas of clinical care (61 percent). These issues are also discussed in a separate [Health Affairs article that focuses on the potential impact of pay for performance \(P4P\) on racial and ethnic disparities](#).

In addition, the survey results indicate much less support among internists for public reporting than for financial incentives for quality, with only 45 percent of respondents supporting public reporting of medical group performance and 32 percent supporting reporting of individual physicians' performance .

The researchers suggest three main implications of their findings for public and private policymakers: (1) there is a large potential reservoir of physician support for P4P; (2) evaluations of P4P and public reporting programs should be designed to assess possible unintended consequences; and (3) the gap in physician support between P4P and public reporting programs is something policymakers may want to consider when designing and sequencing their programs.

### **Joint Commission Releases 4-Year Report on Quality & Safety**

On March 20, the Joint Commission issued the first of what will become an annual report, [Improving America's Hospitals: A Report on Quality and Safety](#), which presents how more than 3000 accredited hospitals performed against evidence-based quality measures relating to the care of heart attacks, heart failure, and pneumonia between 2002 and 2005, and to surgical infection prevention during 2005. Results demonstrated improvements in care for heart attacks, heart failure, and pneumonia that ranged from 1.1 percent to 42.8 percent over the four-year period. The report also identifies 2005's top compliance issues (i.e., quality standards that were the most difficult for hospitals to meet) and performance data measuring hospital compliance with The Joint Commission 2005 National Patient Safety Goals and requirements.

Although the report shows good progress, it also finds that there is room for improvement on most measures, there is considerable variability in hospital performance by state, and there is variability in compliance with the National Patient Safety Goals. The data also shows that some hospitals perform better than others in treating particular conditions. Detailed results for specific hospitals can be found at [www.qualitycheck.org](http://www.qualitycheck.org).

### **IHI Promising Practice of the Month: Outpatient Medication Reconciliation**

The problem of medication errors and mix ups, sometimes with tragic consequences, has led to major efforts to improve medication safety in hospitals. Now medication reconciliation strategies that proved beneficial in the inpatient setting are taking the next step. The best error prevention strategies focus across the health care continuum, include outpatient providers, and engage patients and their families. To read more, click [here](#).

*The House 21<sup>st</sup> Century Health Care Caucus thanks the following organizations for their contributions to this newsletter:*

*HIMSS (Healthcare Information and Management Systems Society) is the healthcare industry's membership organization exclusively focused on providing leadership for the optimal use of healthcare information technology and management systems for the betterment of human health. HIMSS frames and leads healthcare public policy and industry practices through its advocacy, educational and professional development initiatives designed to promote information and management systems' contributions to ensuring quality patient care. On the web at [www.himss.org](http://www.himss.org). (Items 3-7)*

*The Institute for Healthcare Improvement (IHI) is a not-for-profit organization leading the improvement of health care throughout the world. Founded in 1991 and based in Boston, MA, IHI is a catalyst for change, cultivating innovative concepts for improving patient care and implementing programs for putting those ideas into action. Thousands of health care providers participate in IHI's groundbreaking work. To find out more, go to [www.ihl.org](http://www.ihl.org). (Item 12)*

*The National Quality Forum (NQF) is a private membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting. NQF's mission is to dramatically improve quality of care. Its portfolio includes the endorsement of performance measurement consensus standards, educational programs for health care leaders on key environmental trends, and award recognition programs. NQF, a non-profit organization with diverse stakeholders across the public and private health sectors, was established in 1999 and is based in Washington, DC. NQF's Executive Institute works to assist healthcare leaders in making quality health care the key business strategy of their institutions and the healthcare enterprise overall. To find out more, go to [www.qualityforum.org](http://www.qualityforum.org) and [www.NQFExecutiveInstitute.org](http://www.NQFExecutiveInstitute.org). (Items 8-11)*